November 8, 2002

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0235-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5251. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on ___ external review panel who is board certified in orthopedic surgery. ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 41 year-old male who sustained the work related injury to his back while lifting a heavy pipe in ___. He sought emergency room treatment in ___ on several occasions due to pain. A radiology report dated ___ noted mild degenerative changes. The member was treated with Vicodin, Mobic Flexeril and Skelaxin. He underwent an umbilical hernia repair on 11/15/01. He has also received physical therapy. A lumbar discogram was performed on 7/11/02. The report from this procedure indicated that discs L1-2, L2-3, L4-5 and L5-S1 had torn annulus and concordant pain. A postdiscogram CT scan was performed. The report indicated that L1-2 and L3-4 were Grade II and L2-3 and L4-5 were apparent Grade II with probable herniations.

Requested Services

Outpatient intradiscal electrothermal therapy (IDET)

Decision

The Carrier's denial of authorization and coverage for the requested surgery is upheld.

Rationale/Basis for Decision

___ physician reviewer explained that the medical and scientific literature does not provide strong support for the use of IDET. ___ physician reviewer noted that a recent clinical review of IDET concluded that this procedure lacks peer reviewed journal evidence of its mechanism of

action and randomized well-controlled studies to demonstrate its efficacy. (Heary, R.F. Intradiscal electrothermal annuloplasty: The IDET procedure. Journal of Spine Disorders, Vol 14 #4, 2001.) ___ physician reviewer indicated that other articles have concluded that additional study of this procedure is needed. (Darby, R et al. Intradiscal electrothermal anuloplasty (IDET): A novel approach for treating chronic discogenic back pain, Neuromodulation 3:82. 2000. Karasek, et al. Twelve month follow-up of a controlled trial of intradiscal thermal anuloplasty for back pain due to internal disc disruption. Spine 25: 2601. 2000.)

___ physician reviewer explained that well proven therapies are available for treatment of patients with back pain. ___ physician reviewer also noted that in this case, multiple discs showed concordant pain and that only one level could serve as a control. ___ physician reviewer indicated that it is unlikely that multi-level IDET would be beneficial for treatment of this particular patient's condition.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,